EN-CLER BIOMEDICAL WASTE PVT. LTD.

H.O. - 1004, The Rajhans Montessa, B/s Le-Meridien Hotel,
Dumas Road, Magdalla, Surat – 395007
Phone No.: (0261)2992411 E-Mail: bmw@en-cler.in

MEMBERSHIP REGISTRATION FORM

Name of the Health Care Facility/ Industry/ Occupational Health Care :		
Doctor's Name :		
Address :		
	City :	**Taluka :**
District :		
Pin code :		
E-mail :		
Pan card No. :		
Mobile :		
Tel. No. :		
GST No. :		
Status of Health Care Facility	☐ Proprietor ☐ Huf ☐ LLP ☐ Partnership firm ☐ Company ☐ Trust ☐ Aop	
Type of Generator **√ mark in front of generator**		Hospital (General/Maternity/Surgical/Children/ENT/Heart Kidney/ Orthopedic/ Cancer/ Nursing Home/Physician)
		Dispensary
		Dental Clinic
		Laboratory
		Medical College
		Pharmaceutical Company
		Research Institutions
		Veterinary
		Occupation Health Center — No. of Employees :
		Others (Specify)
Type of Health Care Facility	☐ **BEDDED** ☐ **NON-BEDDED**	

EN-CLER BIOMEDICAL WASTE PVT. LTD.

H.O. - 1004, The Rajhans Montessa, B/s Le-Meridien Hotel,
Dumas Road, Magdalla, Surat – 395007
Phone No.: (0261)2992411 E-Mail: bmw@en-cler.in

No of Beds :-		**No. of Department/ward :-**	
Registration No. :-		**No. of Outdoor Patient/Day :-**	
Waste Collection Service :	**Door To Door :** Everyday / Alternate day		**Vehicle Start From :**

Document Check List		
Proprietor	1. Aadhar card of Proprietor 2. Pan card of Proprietor	3. Letter Head 4. Address Proof
Company	1. Company pan card 2. Incorporation certificate 3. Letter Head	4. Address Proof 5. Director's ID
Partnership firm, LLP	1. Pan card of Partnership firm/LLP 2. Incorporation certificate if Applicable 3. Partner ID proof	4. Partnership deed 5. Letter Head 6. Address Proof
Trust	1. Trust Pan card 2. Trust registration 3. Trustee ID proof	4. Trustdeed 5. Letter Head 6. Address Proof
HUF	1. Aadhar card of Karta 2. Pan card of Karta	3. Letter Head 4. Address Proof

Along with the above documents, Doctor's ID Proof, Medical Practitioner Registration and Qualification Certificate and GST Certificate if Applicable are compulsory for all categories of HCF.

Contact Person Name :		**Signature :**	
Designation :		**Date :**	

Remarks: All information and documents provided in this form are in my knowledge and if found incorrect or misleading at any Stage, you may reject or cancel membership registration.

FOR OFFICE USE ONLY

Membership Form Received for		**Surat**	**Vapi**
Membership Code :		**Receipt No :**	**Receipt Date :**
Certificate Validity Date :			
Area Code :		**Deposit :**	
Billing :	**Vehicle Start From :**	**COMMENTS / REMARKS :**	
Waste Collection Service :		**Payment Date :**	
Checked by :			

Remarks: Please note that Name and address mentioned in the form and membership Number allotted by the organization will not be changed in any circumstances. All the payments will be accepted through banking channels only. Membership Fees is Non-Refundable under any circumstances.